

South East
LOCAL HEALTH INTEGRATION NETWORK

**Your LHIN, Your Health Care.
Be Part of the Future.**

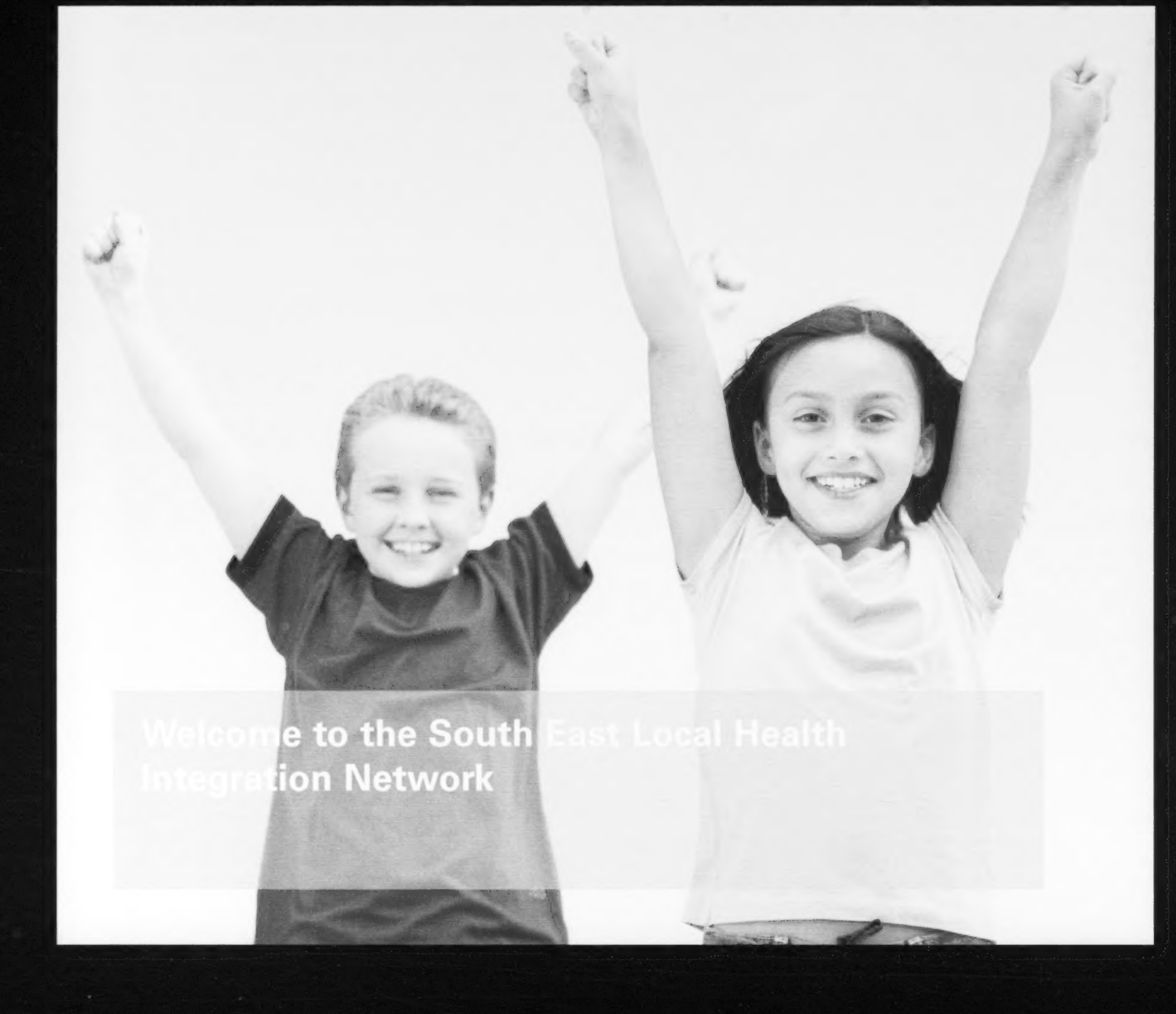
South East LHIN – 2005/06 Annual Report





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A black and white photograph of two young children, a boy on the left and a girl on the right, both smiling broadly with their arms raised in a celebratory gesture. The boy is wearing a dark t-shirt, and the girl is wearing a light-colored t-shirt. The background is a plain, light color.

**Welcome to the South East Local Health
Integration Network**

The following is an overview of the South East Local Health Integration Network (SE LHIN) using the most recently available data on social and demographic characteristics, health status, health practices and outcomes of the population. Rates or proportions for Ontario are provided as a comparator.

Relative to the province, the South East has a higher

- proportion of seniors
- proportion reporting activity limitations
- prevalence of people who are overweight or obese
- proportion of daily smokers
- flu shot rates
- prevalence of arthritis/rheumatism as well as heart disease
- age-standardized all-cause mortality and hospitalization rates and a lower
- proportion of immigrants and visible minorities
- proportion of Francophone's
- life expectancy at birth for males and females

The South East LHIN has a sizeable rural population, with 44% of the population living in communities of fewer than 10,000 people. The South East LHIN is also much more homogenous linguistically and home to the largest proportion of people over the age of 65 in the province. The South East LHIN has the highest rates of arthritis/rheumatism and heart disease – two health outcomes that are closely associated with age – of all LHINs.

For additional information regarding the Local Health Integration Network organization and the Local Health System Integration Act 2006, please refer to Appendix "A"

Message from the Chair



As I reflect on our first year of operation, I do so with great pride as I see a year filled with significant changes and accomplishments. I am honoured to have been chosen as one of the first LHIN Chairs in this long-overdue transformation of our health care system - a transformation that will ensure the sustainability of this precious resource that is viewed by many as the best health care system in the world.

Let me begin my remarks by thanking the Minister for having the wisdom and courage to recognize that this vast health care system cannot be effectively managed from "head office" in Toronto. I also wish to thank my board colleagues and our limited staff for their dedication to this exciting journey made possible by the commitment and support of the SE LHIN community, who have embraced the vision "a health care system that helps people stay healthy, delivers good care to them when they are sick, and will be there for their children and grandchildren" into a reality. Your partnerships are making the vision a reality.

In my 28 years in the health care profession, I have never had the privilege of being involved in such a compelling cause as the one in which we are now engaged. Over the past year we have had the opportunity to engage our community in conversations they have never before experienced - conversations that have given them, and will continue to give them, the opportunity both to identify our local health care needs and to be heard as equals around the table.

A number of events have brought us to this point. It began in early 2004 with a series of workshops around the province that were the jumping-off point in the identification of key needs and priorities throughout the health care system. The process of engaging local communities at that early stage by the Ministry was, in my opinion, the start of the building of a strong foundation on which to begin our work. I had the privilege to be one of the participants at the South East workshop and I saw first hand the self-identification of key local issues. We also observed the beginning of community-developed "Planning Contacts", which have gone a long way in helping us to connect with key individuals in those

communities. The two key areas of patient care and administrative support presented for discussion by the Ministry produced a total of 142 integration priorities for the fourteen LHINs to use as starting points. It is interesting that the two priorities that stood out spoke to the two key areas presented by the Ministry for discussion: 1) the high level of frustration experienced by patients trying to navigate through the maze of our health care system; and 2) the realization that provider staff did not know how to navigate the system either.

June 2005 saw the announcement of the creation of fourteen Local Health Integration Networks, followed by the announcement in July of the first three board members. In August, the Incorporation/Letters Patent and the Memorandum of Understanding (MOU) were signed between Her Majesty the Queen in the Right of Ontario represented by the Ministry of Health and Long-Term Care and the LHINs.

In August 2005, our Chief Executive Officer (CEO) was hired and, following an initial orientation session, the three board members and the CEO started our official community engagement processes. The SE LHIN is pleased to report that in the last six months of our first year we have met with over 300 organizations comprising 4,000 individuals from various local health agencies, consumers, families and Municipal representatives. These initial meetings were crucial in setting the tone of our relationships with our partners. I believe that we have developed meaningful ties with our communities that will go a long way to achieving our goals as we move forward. It is the board's feeling, after traveling throughout the LHIN to meet with the communities, that, while there were some initial negative comments, the overwhelming response has been positive with an expressed eagerness to get started on our task.

In November 2005, two more board members were added, with the third appointed a month later. At the same time the board was in the process of recruiting three community members to help us in our search for the final three members of the board. The task of the committee was to ensure we would have members with a well-rounded set of skills on the board. The Nominating Committee was pleased to receive approximately forty applications for the final three positions. Six successful applicants were short listed; and the final three members passed their Order in Council (OIC) and were appointed to the board in March. I want to use this opportunity to once again thank the community representatives for taking the time out of their busy schedules to help in selecting the final members. The now completed board has begun the process of getting to know one another and is gaining a sense of the tremendous talent we have around the table, ready to serve the communities in the SE LHIN.

Educational initiatives that will enable us to become a high level functioning board are in progress. The same educational sessions will be offered to our community partners that will ultimately allow everyone to function at the same level as we plan together for the future health of our community.

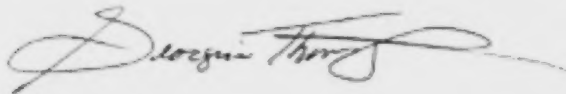
The board has begun the process of establishing the required committees of the board such as Audit Committee, Finance Committee, Governance and Nominating and the Chief Executive Officer Committee (CEO), which conducted its initial function in March with the evaluation of the CEO. I was pleased with the outcome of that evaluation, while recognizing the limited resources available not only to the board, but to the CEO.

The most historic and exciting day for the board and, I believe, the community, was March 1, 2006, with the passing of the health care legislation proclaiming "The Local Health Integration Act 2006". A second exciting day was March 28, 2006, when the "Act, 2006" received Royal Assent. The passing of that historic piece of legislation and granting of Royal Assent was a signal that the people of the Province of Ontario wanted a change in how our health care system was being managed and delivered. This is further echoed in the positive responses the board received during our early community engagements and continues to hear as we moved forward with our mandate. As the community and our board continue to pursue our mandate to successfully "transform" our health care system together, our ability to conduct our conversations in a transparent and inclusive manner will be even more crucial.

As a board, we look forward to the fiscal year 2006-2007, a year that will launch our first Integrated Health Service Plan (IHSP), a plan developed in cooperation with the community because we recognize that we require the community's input into the plan to ensure we accurately identify local needs and look forward to engaging our community again in helping to shape the future of health care locally and in cooperation with our partners across the province. I would like to close with a quote from Henry Ford:

"Coming together is the beginning, working together is progress, and staying together is success". Here's to success.

Yours truly,



Georgina Thompson, *Chair/President*



Florence Campbell, *Vice Chair*

Message from the CEO



March 31, 2006 marked the 222nd day of operations of the South East Local Health Integration Network. These early days were focused on establishing a new organization and office; developing relationships with our communities and embarking on our new mandate. Looking back, during this start up period, it is with a strong sense of pride that I reflect on our accomplishments and with excitement that I look forward on the potential of our local health care system.

The South East Local Health Integration Network is one of 14 such organizations designed by the Ontario Government and led by its visionary Minister of Health, George Smitherman. Its purpose is to more effectively manage the health system at the local level such that the province's massive moral enterprise, the 35.4 Billion dollar health care industry, becomes more patient centred and responsive to the ever changing needs of the communities.

Your South East Local Health Integration Network is responsible for following six mandates:

- Local Health System Planning (Integrated Health Services Plan)
- Integration
- Performance and Accountability Agreements
- Measuring and Reporting Performance
- Funding of Health Services
- Community Engagement

In August 2005 we, the three appointed Board Members and myself as the first Chief Executive Officer, began to build our organization. A temporary office in Kingston held the first few Board meetings. Early office activities were directed at developing financial policies and procedures; identifying staffing requirements; preparing the permanent office in Belleville; and working closely with the good people of the Ministry's Health Restructuring Team. Without the help of Hugh MacLeod, Assistant Deputy Minister of Health and Gail Paech, LHIN Lead, and their team of talented and supportive staff, we would still be working through many tedious start-up issues.

Through the winter months the office further developed with the hiring of four additional staff, including Sherry Kennedy, Senior Director of Performance, Contracts and Allocations; Nancy Sears, Senior Director of Planning, Integration and Community Engagement; Jacqui Prospero, Executive Assistant to the CEO; and Paula Heinemann, Office Manager. Together this talented and passionate group developed a team culture conducive to enthusiastically supporting the mandates of the South East Local Health Integration Network.

Much of the initial activity of the South East Local Health Integration Network was focused on community engagement and the first South East Integrated Health Services Plan development. Our beginning efforts in community engagement were specific to the building of relationships with our health providers and the public, and participating in discussions about opportunities for improving our health system. The Chair, Georgina Thompson and I met with approximately 4,000 people and over a hundred organizations and groups to learn about their services and partnerships; to introduce the concept of LHINs; and to understand the local health care environment.

Later the South East Local Health Integrated Network prepared for the development of its first Integrated Health Services Plan (IHSP) by outlining a process that would incorporate the views of our residents and providers of care, as well as an understanding of the current and projected demands on our system. Included in this extensive planning was the preparation for a focused community engagement that would reach another 1,000 people through 109 meetings in 22 separate communities in the South East. This qualitative analysis became a critical aspect of our integrated health services planning and put into perspective the learnings from a very comprehensive quantitative analysis.

Additionally, the South East Local Health Integration Network began holding system meetings to discuss integration opportunities, such as its session on wait times and meetings with local networks and alliances on evolving our system of care.

Early accomplishments create an appetite for the future and what we are capable of achieving through partnerships with the great people of the South East. We are fortunate to have a strong health care system in Ontario and particularly in the South East. The very valuable resources which support our system, however, must be maximized to ensure that we have the very best system of health and care for our residents. I believe that the South East Local Health Integration

Network has the ability and passion to support and lead our talented and dedicated team of health professionals in the South East to the highest level possible.

Leyland Kaiser, a well respected health futurist, has said:

There are three components of an effective system:

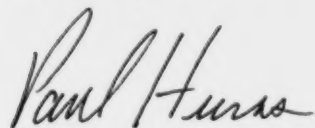
Good people,

Working in appropriate relationships,

Pursuing a common vision.

I am proud to be part of a dynamic team that recognizes how fortunate we are to work within a local system that includes some of the best health care people in the world. I believe that the South East Local Health Integration Network will enable these health care professionals to confirm a common vision and develop the appropriate relationships required to evolve our system to its maximum potential. Our future is bright and exciting. Today is a rewarding time to be part of the health care system.

Yours truly,

A handwritten signature in black ink, appearing to read "Paul Huras". The signature is fluid and cursive, with the first name "Paul" being more prominent than the last name "Huras".

Paul Huras, CEO

Our Leadership Team



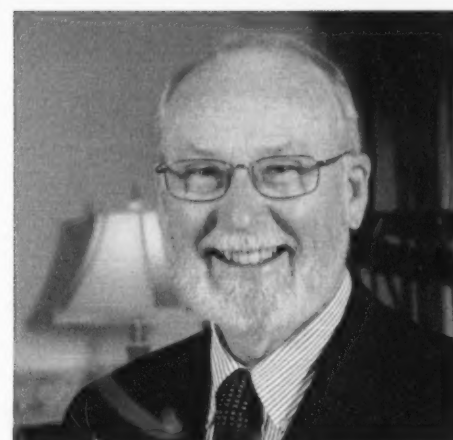
Georgina Thompson, Chair
RN, Bsc.N (Belleville) Term – 2005 - 2008

Georgina Thompson, is founder and past president of All Care Health Services Limited from 1981 to 2005. She also served as a nursing consultant with Plainfield Community Homes from 1989 to 2005. Georgina was an emergency department nurse at Trenton Memorial Hospital from 1981 to 1995, and was a nurse at Belleville General Hospital from 1978 to 1981. She served as a Councilor with the Municipality of Thurlow from 1986 to 1995, and with the City of Belleville from 2003 to 2005. Thompson has also served on a number of community boards in the past, too numerous to mention. She was awarded the Premier's Award for her achievements in the field of Health Science in the College System (1993), was awarded Business Women of the Year Award for Hastings & Prince Edward Counties in 2002 and received the Harry Jerome Award in 2003.



Florence Campbell, Vice Chair (Kingston)
Term – 2005 – 2008

Florence Campbell, is a retired senior executive. During her career, Campbell worked as Vice Principal at Queen's University, Vice President with the Conference Board of Canada, and held various managerial roles with IBM Canada. Campbell has an extensive background in community board governance, having served on organizations such as the Children's Hospital of Eastern Ontario Foundation, the Advisory Board of the Ottawa Heart Institute, and the Kingston General Hospital (including Chair, Planning and Research Development Committees). Current board involvement includes the Community Foundation of Greater Kingston and the Grand Theatre Restoration Committee.



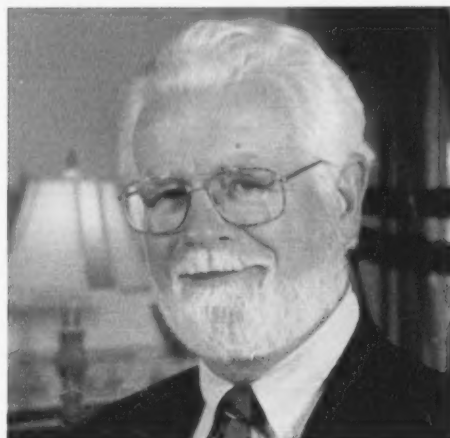
Ian Wilson, Board Member (Amherstview)
Term 2005 – 2008

Ian Wilson, is the dean of Business Administration at St. Lawrence College in Kingston. A former municipal politician, he served as reeve of Ernestown Township and warden of Lennox and Addington County. Wilson has had a broad volunteer involvement in health care as a member and chair of the Board of Directors of Kingston General Hospital; a board member and chair of the Kingston, Frontenac, Lennox and Addington Health Unit; a member of the Kingston Frontenac, Lennox and Addington District Health Council; and a member of the Kingston, Frontenac, Lennox and Addington Community Care Access Centre.



John Groves, Board Member (Brockville)
Term 2006 – 2008

John Groves, worked as a Foreign Service Officer for the Department of External Affairs, (now Foreign Affairs) from 1967 – 1996. He served abroad in Berlin, Bonn and Dar es Salaam. His assignments included periods as director of international energy policy, director of foreign services benefits and director of locally engaged staff. Other assignments with the federal government included positions at the Department of Energy, Mines & Resources; National Health & Welfare; economic adviser to the Northern pipeline Agency; and director of Trade & Tourism for Nova Scotia. Groves devotes much of his present time to community work including The Primate's World Relief and Development Fund, Meals on Wheels, Community Alpha and Loaves and Fishes. He is a warden of the Anglican parish of St. Lawrence and is involved in many outreach liturgical and organizational facets of parish life.



Kenneth Alan McBain, Board Member (Madoc) Term 2006 – 2008

Ken McBain, has had a 40 year career in health care administration. His management experiences have covered a broad spectrum of health and allied health arenas in service delivery, education and training, and health care policy at local and national levels. Mr. McBain earned his university degree in Business Administration in 1962 and went on to hold chief executive roles in university medical training, homecare, primary care and specialty physician practices, community health centres and hospital finance. In addition to administering direct health care series, his responsibilities have included dentistry, pharmacy, behavioral / mental health, lab and radiology. While a native of the U.S., McBain returned to the Madoc area where his family has had a continuous presence since originally settling there in the mid 1800's. Since "retiring" in 2004, he has been a director with the Centre Hastings Medical Centre Corporation and served on the Central Hastings Sustainable Communities Association board as well as participation in the Hastings – Prince Edward Rural Health Sciences Network.



Gaye McGinn, Board Member (L'Amable)
Term 2006 – 2007

Gaye McGinn, has worked in the fields of health care aid, dental assisting, real estate and was a business entrepreneur. Her main focus has always been on customer service and satisfaction. In 1986 – 87, McGinn returned to school, and graduated in the legal administrative course at the Toronto School of Business and went on to become the vice-principal of the Toronto School of Business in Oshawa. As a team member working with the directors, the principal and other administrative staff, McGinn helped develop operation procedures, curriculum, and performance standards. She was also in charge of compiling reports for financial analyses, and maintaining an archive of all school records. McGinn has served on many volunteer boards over the years, and most recently was part of the driving force in establishing a Bereavement Support Group under Hospice North Hastings. She is a trained bereavement facilitator.



Balmukund Patel, Board Member (Stirling)
Term 2006 - 2008

Balmukund Patel, has been the owner of Balu's Pharmacy in Stirling since 1993. Prior to this he was pharmacy manager of Boots the Chemists in Chatham; co-owner of Village Square Pharmacy in Scarborough; and owner-associate of Shoppers Drug Mart in Keswick. Patel earned his Bachelor of Pharmacy degree in 1977 at the University of Bath in England. He is president of Quinte Area Pharmacists' Association, board member of the Diabetes Education Centre and organizes the annual Quinte Area Pharmacists' Charity Golf Tournament.

Thomas Rankin, Board Member (Merrickville)
Term 2006 - 2007

Tom Rankin, Brings to his position as Board member of the South East Local Health Integration Network 30 years of public service experience. Prior to his 27 years with the Government of Ontario, he worked in communications with the University of Waterloo. He held positions in the Department of Education, Community and



Social Services, Culture and Recreations, Tourism and Recreations and Economic Development and Trade. When he retired he was a Regional Director with Culture, Tourism and Recreations. Leadership development has been a major part of his career and he moderated executive development programs with the Niagara Institute and the Canadian Centre for Management Development. Over the last eight years since his retirement he has held a number of volunteer positions with health care organizations including: Board Chair, Access Centre for Community Care in Lanark, Leeds and Grenville; Vice-Chair, Access Centre for Community Care in Lanark, Leeds and Grenville; Vice-Chair, Ontario Association of Community Care Access Centres; Executive Member, Merrickville District Community Health Centre. Today he uses his Math and Physics degree from the University of Waterloo in the math tutoring business he runs with his wife Marian. Tom and Marian have three daughters, all graduates from health sciences programs at McMaster University, and employed in the health care field.



Margaret Werkhoven, Board Member
(Prince Edward County) Term 2006 - 2007

Margaret Werkhoven retired from the Hastings and Prince Edward District School Board in 1999, after a 35 year career in education as a secondary school teacher, vice principal, and superintendent. She is a graduate for the University of Western Ontario, Honours BA (English and Latin). Margaret is a member of the Board of Governors of Loyalist College of Applied Arts and Sciences; and sits on both the local executive and the Provincial Constitution Committee of the Retired Teachers of Ontario. She serves on a number of local community boards, including the Quinte Arts Council, Youth Habilitation Quinte, the Learning Foundation of Hastings and Prince Edward, and the Parish Council of Christ Church. She was a recipient of the Sir MacKenzie Bowel Award for Educator of the Year (1999). Margaret is married to Harold, a retired Prince Edward County dairy farmer; and is the mother of two children and the grandmother of three.

Inside Our LHIN

Our Population

The South East LHIN is home to 442,800 people, or 3.8% of the population of Ontario. During the 1994-2004 time period the population of the South East increased, on average, by 0.5% each year. The population of Ontario increased by 1.5% annually during this same time. **Table 1** provides an overview of the social and demographic characteristics of this population. Compared to the provincial average, the South East has a greater proportion of seniors and a much smaller proportion of immigrants and visible minorities. Fewer residents of the South East are Francophone (i.e.

claim French as their mother tongue) compared to the province as a whole. The unemployment rate in the South East is similar to the provincial rate and relative to the province a smaller proportion of the South East residents are in low income. Forty-six percent of adults (age 20+) have attained post-secondary education credentials, but just over 27% have not completed high school.



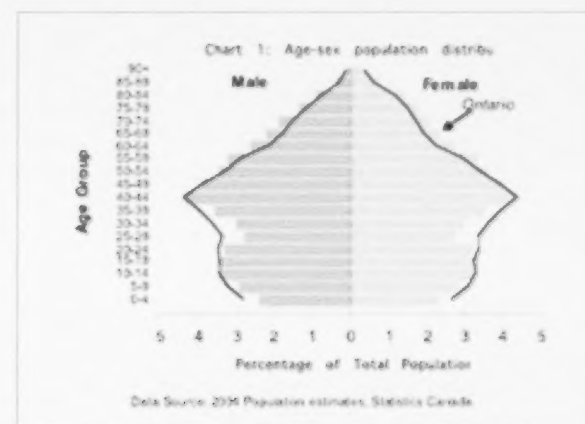
Table 1: Socio-demographic characteristics

	SOUTH WEST	ONTARIO	LHIN Range
Total population (2004)†	442,800	12,392,700	242,500 - 1,542,900
Senior population, age 65+ (2004)†	15.7%	12.8%	9.4 - 15.7%
Population with English mother tongue	92.2%	71.9%	55.7 - 92.2%
Population with French mother tongue	2.6%	4.7%	1.2 - 25.1%
Population who are immigrants	9.2%	26.8%	6.4 - 45.7%
Population who are recent immigrants (arrived between 1996-2001)	0.7%	4.8%	0.3 - 9.7%
Population who are visible minorities	2.7%	19.1%	1.3 - 38.8%
Population of Aboriginal identity	2.0%	1.7%	0.3 - 13.9%
Labour force participation rate (age 15+)	62.5%	67.3%	60.0 - 72.0%
Unemployment rate (age 15+)	6.9%	6.1%	5.0 - 9.8%
Population in low income	13.4%	14.4%	10.0 - 22.3%
Families (with children) headed by a lone parent	24.1%	23.4%	19.4 - 30.0%
Population (age 20+) with less than grade 9 education	7.2%	8.7%	6.3 - 12.0%
Population (age 20+) without high school graduation certificate	27.3%	25.7%	19.2 - 33.4%
Population (age 20+) with completed post-secondary education	46.4%	48.7%	42.4 - 55.8%

Data Source: 12004 Population estimates. Remaining indicators based on 2001 Census of Canada.

Chart 1 shows the population structure of the South East. The black line provides the Ontario population distribution for comparison. The population pyramid shows that the population structure of the South East area is similar to Ontario's, with a higher proportion of the population in the elderly age groups, and a lower proportion in the 20-39 year age groups.

Chart 1: Age-sex population distribution

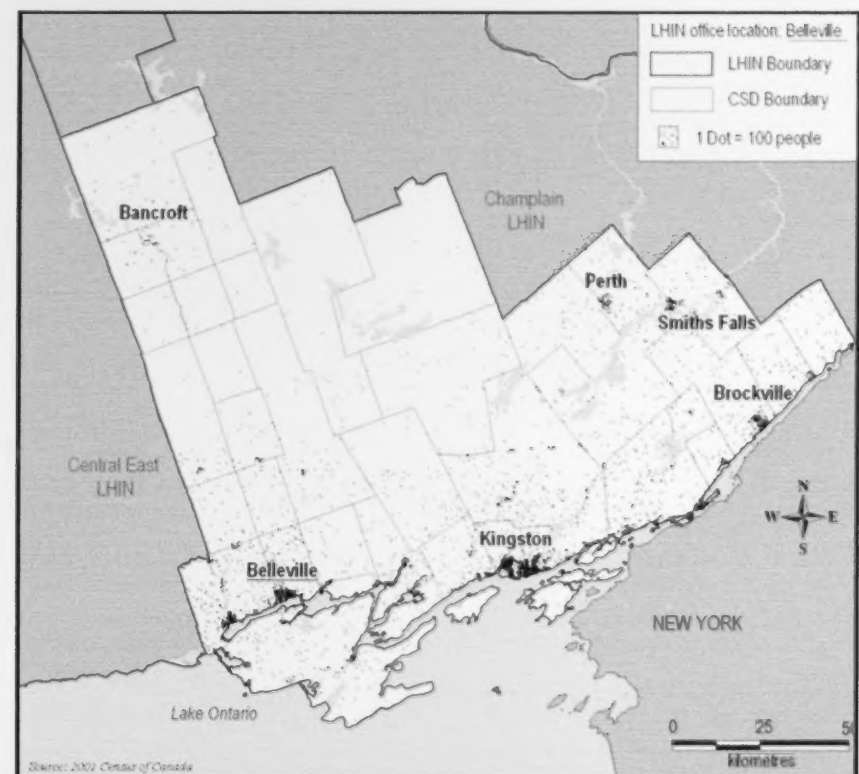


Data Source: 2004 Population estimates, Statistics Canada

Map 1 shows the 2001 population distribution (mapped by dissemination areas) within the South East LHIN area. Census subdivision (CSD) boundaries (analogous to municipal boundaries in most areas) and the names of selected communities are shown for reference. One quarter of the South East population resides in the Kingston CSD (population of approximately 114,200), with Belleville

(46,000), Quinte West (41,400) and Prince Edward (24,900) CSDs following as the next most populous areas (10%, 9% and 6% of the population respectively). The remainder of the South East is made up of CSDs ranging in population size from 360 people (Limerick) to approximately 21,400 (Brockville).

Map 1: 2001 population distribution within the South East LHIN area



Health Status

Life expectancy at birth is the average years of life an individual could live on the assumption that current, cross-sectional age-specific mortality rates remain constant over the life span. Life expectancy among males and females in the South East is significantly lower than life expectancy for Ontario overall (Table 2). Low birth weight is an important determinant of infant morbidity and mortality. In the South East 5.6% of infants born in 1999-2001 were of low birth weight. Infant mortality is a long-established measure, not only of child health, but also of the well-being of a society. The infant mortality rate in the South East of 5.0 per 1,000 live births is similar to the provincial experience. Self-reported health, an indicator of overall health status, can reflect aspects of health not captured in other measures, such as disease severity, aspects of positive health status, physiological and psychological reserves and social and mental function. Residents of the South East report their health as "Excellent" or "Very Good" at rates that are slightly, but not significantly, lower than the province as a whole. A significant proportion of residents (30.0%, compared to 24.6% provincially) report being limited in their activities because of a physical or mental condition or health problem which has lasted or is expected to last longer than six months.



Table 2: Health status

	SOUTH EAST	ONTARIO	LHIN Range
Female life expectancy at birth (years), 2001†	80.3* (±0.6)	82.1 (±0.1)	79.5 - 82.2
Male life expectancy at birth (years), 2001†	75.7* (±0.6)	77.5 (±0.1)	74.7 - 80.6
Low birth weight babies (1999-2001)‡	5.6%	5.6%	3.7 - 6.2%
Infant mortality rate per 1000 livebirths (1999-2001)††	5.0 (±1.4)	5.4 (±0.2)	3.9 - 6.1
Population who say their health is Excellent or Very Good, 2003 (age 12+)§	55.0%* (±2.5)	57.4% (±0.7)	51.0 - 61.5%
Population with an activity limitation, 2003 (age 12+)§	30.0%* (±2.9)	24.6% (±0.6)	19.3 - 30.0%

* Significantly different from provincial average based on assessment of 95% confidence intervals

Data sources: † Ontario Vital Statistics, Mortality Database, ‡ Ontario Vital Statistics, Livebirths Database

§ Canadian Community Health Survey, 2003

Health Practices and Preventative Care

Poor health practices are known to be related to increased risk of chronic disease, mortality and disability. **Chart 2** shows that, relative to the province, those in the South East are significantly more likely to be overweight/obese. Based on Body Mass Index, 36.8% of the adult population of the South East is considered overweight and 16.8% are obese. Compared to the provincial average the South East also has a significantly higher prevalence of daily smokers. The proportions of both heavy drinkers and those who are physically inactive are also greater in the South East compared to the province, but these differences are not statistically significant. Similarly, the prevalence of life stress is lower in the South East but not significantly so.

The use of preventive health care services can lead to early detection of disease, which ultimately results in reduced morbidity and mortality. Mammography and Pap smear rates (for cervical cancer screening) among women in the South East are similar to the provincial rates (see **Table 3**). Residents of the South East are significantly more likely to have had a flu shot in the past year (39.0%) compared to the province as a whole (34.2%).

The point of access for most medical care is through a primary care physician. Medical doctors also play a key

role in coordinating care and managing chronic conditions. The majority of people (82.4%) in the South East had at least one contact, either in person or by phone, with a medical doctor in the past year. This percentage is similar to the Ontario rate of 81.4%.

Chart 2: Health practices, population age 12+

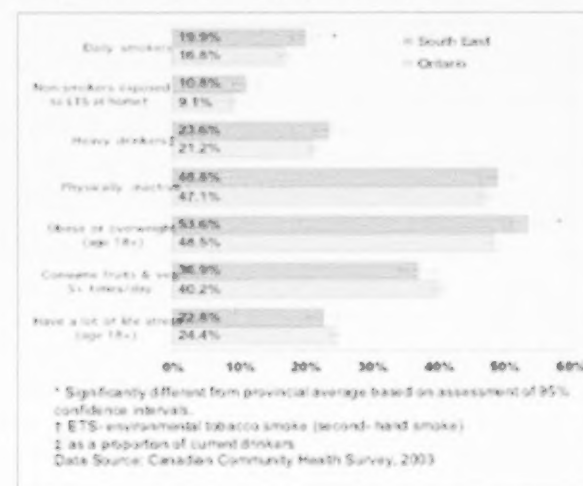


Table 3: Use of preventive care

	SOUTH EAST	ONTARIO	LHIN Range
Had mammogram in past 2 years (females age 50-69)	71.8% (±4.8)	70.6% (±1.9)	65.8 - 77.2%
Had Pap smear test in past 3 years (females age 18+)	70.0% (±3.5)	69.2% (±1.0)	65.4 - 75.5%
Had flu shot in past year (age 12+)	39.0% (±2.4)	34.2% (±0.7)	30.3 - 39.0%
Contact with medical doctor in past year (age 12+)	82.4%* (±1.9)	81.4% (±0.6)	76.4 - 83.7%

* Significantly different from provincial average based on assessment of 95% confidence intervals
Data source: Canadian Community Health Survey, 2003

Morbidity & Mortality

Chronic conditions place a high burden on the health care system and reduce the quality of life of those who suffer from the condition. **Chart 3** shows that the South East has a significantly higher prevalence of arthritis and heart disease and slightly higher rates of other chronic conditions such as diabetes and high blood pressure. Prevalence rates presented in **Chart 3** are not age-standardized, and therefore areas with a high proportion of seniors will tend to have higher rates of chronic conditions.

Table 4 provides age-standardized mortality and hospitalization rates as well as rates for potential years of life lost (PYLL) by ICD-10 chapter. In the South East 19.8% of deaths occur before the age of 65, and 40.2% occur before the age of 75 (the Ontario percentages are

21.3% and 41.2% respectively). All-cause mortality, PYLL and hospitalization rates in the South East are higher than provincial rates. This appears to be due primarily to higher rates of circulatory disease and neoplasms, which are the two leading causes of mortality and morbidity, and to a lesser extent respiratory and nervous system diseases. PYLL rates are useful for quantifying the number of years of life “lost” from deaths that occur “prematurely” (i.e. before age 75). **Table 4** shows that in the South East neoplasms contribute to more years of potential life lost than any other cause, followed by circulatory system diseases, and external causes (i.e. injuries).

Chart 3: Health practices, population age 12+

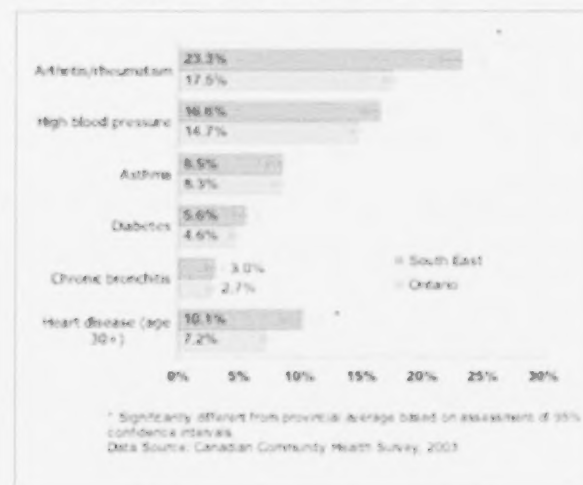


Table 4: Mortality, PYLL and hospitalization rates by ICD-10 chapter

Cause (ICD-10 chapter)	Age-standardized mortality rate per 100,000 (avg. 2000-01)†		Potential Years of Life Lost rate per 100,000 (avg. 2000-01)†		Age-standardized hospitalization rate per 100,000 (2003-04)‡	
	SOUTH EAST	ONTARIO	SOUTH EAST	ONTARIO	SOUTH EAST	ONTARIO
ALL CAUSES	699.7	602.6	6,105	4,864	7,935.4	7,746.7
I. Infectious diseases	10.1	9.3	129.6	122.3	109.8	119.9
II. Neoplasms	200.3	181.4	1,982.6	1,590.3	476.7	549.6
III. Diseases of blood	2.1	2.1	19.8	18.4	66.8	76.2
IV. Endocrine/nutritional disorders	30.1	26.1	236.7	171.0	169.3	173.7
V. Mental & behavioural disorders	16.1	15.0	88.5	59.2	580.2	502.7
VI. Nervous system diseases	31.2	24.8	205.4	142.9	130.3	111.6
VII. Eye diseases	0	-	0	-	13.3	20.1
VIII. Ear diseases	-	-	2.1	1.1	12.8	20.7
IX. Circulatory system diseases	245.2	209.1	1,213.3	852.9	1,092.1	1,007.5
X. Respiratory system diseases	58.6	45.4	238.4	150.5	686.3	624.6
XI. Digestive system diseases	27.6	22.6	232.5	191.1	770.7	761.2
XII. Skin diseases	1.0	1.0	11.6	3.9	64.0	65.9
XIII. Musculoskeletal diseases	4.4	3.8	22.3	24.8	412.3	356.0
XIV. Genitourinary diseases	12.7	11.1	55.1	38.2	437.6	421.0
XV. Maternal conditions	-	0.1	6.0	4.6	1,304.4	1,367.8
XVI. Perinatal conditions	2.8	4.2	148.9	266.5	63.7	71.7
XVII. Congenital abnormalities	4.0	3.1	187.0	158.0	51.3	47.9
XVIII. Symptoms not elsewhere classified	12.1	10.8	253.1	234.0	500.7	457.9
XIX. Injury & poisoning	n/a	n/a	n/a	n/a	648.9	578.6
XX. External causes of mortality	41.1	32.6	1,072.0	834.3	n/a	n/a
XXI. Factors influencing use of services	n/a	n/a	n/a	n/a	343.8	408.6

- Data suppressed due to small numbers

Data sources: † Ontario Vital Statistics, Mortality Database ‡ Ontario Hospital Inpatient Database

Integration Priorities

Health care systems are complex with many competing priorities. Ranking priorities requires an understanding of the issue being addressed, the relative importance of the issue compared to others, the interrelationship of the issue with other issues, and a degree of support for the priority.

In the South East priorities have been identified by at least four separate groups, including the following:

1. Ministry of Health and Long-Term Care
2. Local Health Integration Network (LHIN) Integration Priority Opportunities (Feb 21, 2005)
3. Local Input from General Community Engagement,
4. Quick Start Priorities
5. Draft Integrated Health Services Plan (IHSP).

1. Ministry of Health and Long-Term Care priorities include:

- Wait Time/Access to Care
- Primary Health Care
- System Accountability
- Local Health Integration Networks

2. LHIN Integration Priority Opportunities include:

- Patient Care
- Addiction Services & Mental Health Services Integration
- Innovation in Rural Health
- Urgent Medical Transport
- Client/Patient Navigation at Transitions Across the LHIN
- Integrated Palliative Care Services
- e-Record
- Nurse Practitioners: Improving Integration in all Services
- Rural Community Partnership/Volunteers
- Providing Meaningful Geographic Input to LHIN Planning
- Ensuring Better System Navigation for Clients at the Community Level

3. Local Input from General Community Engagement:

- Primary Health Care Reform
- Non-urgent and Urgent Transportation
- South East e-Health Strategy and Implementation
- Back Office or Non-clinical Services Integration

4. Quick Start Priorities:

In March 2006, the South East Local Health Integration Network requested health care providers to identify their current priorities for improving the local health care system. This request was initiated to confirm the relevance of previously identified priorities. The Quick Start Priorities identified and the number of groups supporting these priorities included:

- Primary Care Reform (4)
- Mental Health and Addictions Integration (4)
- Navigation (3)
- Palliative Care (3)
- Transportation (2)
- e-Health / Health Information (2)
- Rural Access, Local Access, Community Care Access Centres (CCAC)
- Supportive Housing
- Health Care for the Homeless

Draft Integrated Health Services Plan – Action Plan:

- Access to Primary Health Care
- Access to Specialists
- Reduced Wait Times for Treatments
- Access to Mental Health Services and Addictions Services

- Access to Rehabilitation Care
- Transportation To and From Care
- Availability of Long-Term Care Services
- Integration of Services along the Continuum of Care
- Integration of e-Health
- Regional Health Human Resources Plan
- Engagement with Aboriginal Communities

From these sources, there appears to be some commonalities, such as the following priorities for change:

- Primary Health Care
- Wait Time / Access care
- Transportation
- Mental Health and Addictions
- e-Health
- Palliative Care

The South East Local Health Integration Network will develop strategies to address these common priorities in 2006 – 07.

Building on Local Successes

Success Stories

The South East Local Health Integration Network is privileged to work in a health care environment with innovative providers of care. The South East LHIN, with its mandate for enabling integration, is not starting from a blank sheet. The South East is the proud home of many integration success stories, in the areas of Palliative Care, Mental Health and Addictions, Infection Control, Stroke Services, Telehealth, Physiotherapy, Family Health Teams, Community Support Services, Health Care Network, Community Health Centres and many more tremendous efforts to improve the delivery of care in an integrated fashion across this great section of Ontario.

One of the great stories includes the joint effort of Providence Continuing Care Centre to increase access and reduce wait times for outpatient rehabilitation for total hip and knee replacement. Pre-operative education, delivered when the patient is most able to retain the information will improve quality of life, improve post-operative outcomes and efficiencies and minimize delays in discharge from acute care that are associated with delays in learning and skill development. The overall objective of this project was to increase access to outpatient rehabilitation services to minimize length of stay and unnecessary delays in discharge, reduce wait time for outpatient rehabilitation

post hip and knee replacement, improve post-operative outcomes. Project activities included: pre-operative group education, group exercise class in a therapeutic pool and an enhanced referral mechanism to outpatient services.

Through this project, regular meetings of the Wait Time Strategy Community Partner Working Group were established to ensure regular communication and collaboration on initiatives, related to hip and knee replacement populations. Project implementers ensure pre-operative education including a screening day, educational materials and one-on-one counselling with physiotherapists. The Arthritis Society provided group education services. Pre-operative exercise programs for screened patients were also offered. It is important that capacity analysis and improvements be done and this project has contributed to that.

We look forward to assisting organizations to achieve these types of effective integrated efforts to meet the needs of our communities.

Operational Start-Up

Once the policy framework was established by the Ontario Government and Local Health Integration Networks (LHINs) were chosen as the model for integration in this province, it was time to launch LHINs as 14 corporations. In June 2005, 14 news conferences were held across the province to publicly announce the 14 LHIN chairs, 42 founding board members and 14 CEOs.

CEOs began work in August 2005 and worked along side the board chairs to start getting to know the communities they serve. That summer LHIN leaders hosted 37 "Meet and Greet" sessions across the province with 1,500 leaders of health care organizations.

14 offices were set up across the province. To ensure cost-effective and efficient operations, LHINs established a common administration process and have retained a company, CGI, to deliver payroll, financial and human resource services for the LHINs.

By the fall of 2005, all LHIN offices were open and ready-for business. Four staff members were recruited for each LHIN and by January 2006, each LHIN had two senior directors, an executive assistant and an office manager in place. Additional staff will be recruited in the near future.

A business operations manual was created to provide basic policies and procedures related to LHIN business operations. This included government directives that LHINs must comply with, a summary of legislative requirements that govern LHIN practices and standard practices required by the Ministry for all LHINs.

Starting in the summer of 2005 and continuing throughout the year, extensive orientation sessions were held for the

founding LHIN board members and staff. As part of their professional development, LHINs and the Ministry hosted several "Think Tanks" on topics such as funding models, planning, corporate governance, ethics and a framework for ethical decision making. Discussion forums were held to discuss such issues as physicians and LHINs and LHIN cross-boundary issues in the community sector.

Accountability agreements between each LHIN and the Ministry were developed for the years 2005/06 and 2006/07 setting out the key activities that the LHINs are responsible for. LHINs received templates and guidelines for filing quarterly reports to the Ministry.

The South East Local Health Integration Network: The Year in Review

The following is an overview of the year's activities:

LHIN Performance Objectives

1. Establishment of LHIN Governance Policies, Practices and Relationships

A. Community Board Members

The Board has successfully completed its responsibility to submit three community nominees to the Ministry for appointment to the SE Board. It is expected the remaining three Board appointments will be received by the end of April.

B. Development of Performance Objectives and Assessment Tool for the SE LHIN CEO

A small working group of LHIN Chairs and CEOs, including G. Thompson, Chair, SE LHIN, have prepared a draft template for assessing the performance of a LHIN CEO. The Assessment Tool will be presented to the SE Board for development as the SE LHIN assessment tool for its CEO. The Board will need to set Performance Objectives for the CEO within the next few months.

C. Development of a Process to Establish Board Structure

Florence Campbell, Vice Chair and the CEO were directed by the Board during its January 16, 2006 meeting, to plan for a Governance Development process. Discussions have begun and a draft plan is developed which includes

a series of governance sessions to be completed by the end of spring 2006. Mr. Jim Ninniger, former CEO of the Conference Board of Canada and currently a Governance Consultant, has agreed to work with the Board of the SE LHIN to assist with the development of its Governance Model. Mr. Ninniger will meet with the SE LHIN Board on Monday April 10, 2006.

D. Orientation for New Board Members

An orientation session is being prepared by the Ministry of Health and Long-Term Care (MOHLTC) for the full nine Board Members and CEO of each of the 14 LHINs to be held following the final OIC appointments. The SE LHIN will hold a SE specific orientation for its new members. This orientation will take place on Saturday, April 29, 2006.

2. Implementation of LHIN Functions

A. Development of Strategic Relationships and Community Engagement Plan

The Chair, Board Members and CEO have been meeting with Community Provider groups during the first 200 days of the operation of the SE LHIN office. To date they have met with over 4,000 individuals representing over 100 groups and many more meetings have been scheduled. The Board will be reviewing a template for a more formal Community Engagement process in general and as part of its Integrated Health Service Plan (IHSP) process.

B. Integrated Health Services Plan (IHSP)

The SE LHIN CEO served as the lead for LHINs' CEOs, together with the Health Results Team representatives in developing a LHIN IHSP roadmap which was presented to and accepted by the CEOs and Board Chairs on January 22, 2006. Subsequently, a workshop on the IHSP and the community engagement components was held on February 1, 2006. This roadmap has been well received to date. The SE LHIN Board held a lengthy discussion on a process for initiating the Integrated Health Services Plan and approved the process on March 13, 2006. A Request for Proposal was sent out to seven Health System Planning Consulting Firms and a small Review Committee reviewed the proposals on Monday, March 27, 2006. Letters from the SE LHIN Chair and CEO were circulated to the Board Chairs and CEOs of each of the 117 Transfer Payment Agencies (TPA) as a first effort to engage local stakeholders in the process and to introduce them to the approach.

C. Integration Priority Report

A review of the Integration Priority Report which was completed in February 2005 was presented to the Board on February 14, 2006. It will be considered as part of the process for setting the initial priorities for the SE LHIN.

3. Establishment of LHIN Business Operations

A. Staff Recruitment

Staff members for the first four available positions were successfully recruited and all have commenced employment. I am pleased to have as the first members of the SE LHIN staff team the following individuals:

Paula Heinemann, *Office Manager (OM)*

Sherry Kennedy, *Director, Performance, Contracts and Allocations*

Jacqui Prospero, *Executive Assistant (EA)*

Nancy Sears, *Director, Planning, Integration and Community Engagement*

An initial orientation meeting was held for these individuals on Friday, January 6, 2006. A strong team culture has already been evident from such efforts as the Integrated Health Services Plan process and regular team meetings. A provincial orientation was held on January 18 and 19 for the two directors. The LHIN EA and OM groups have each held teleconferences as part of their orientations. Further recruitment for all full time positions will begin in the Summer. There may be some temporary positions filled within the next two months to initiate work on identified priorities. Two temporary positions have been filled to handle the support for the Board and Board Chair and reception duties, and to support the two Senior Directors.

B. Establishment of Business Processes and Back Office

The staff is proceeding with the development of many business processes. These are primarily processes related to start up such as payroll, filing, e-mail access, purchasing, petty cash, etc. Staff members are also supporting the provincial LHIN initiatives to develop several back office functions in Toronto. It is anticipated that the central back office in Toronto will be operational by March 31, 2006 to coincide with the sunset clause of the Health Results Team. Significant progress has been achieved on the development of the Shared Services model for the LHIN Toronto back office.

C. Operational and Financial Reporting

The Chair is providing a regular report as a standing item on the Board Agenda, about the Chairs teleconference meetings.

The CEO is providing the Board with a SE LHIN Performance Agreement 2005/2006 - Monthly Update on how the organization is progressing with its performance obligations. This Monthly Update can be considered a Monitoring Report consistent with one of the Board's Governance responsibilities.

The CEO is also providing a separate CEO Monthly Report which provides the Board, for its information, an update on other operational issues.

The SE LHIN Board has approved the 2006 / 2007 final budget on Monday, March 27, 2006. The Budget for the

SE LHIN reflects the population density of the area, the number of transfer payment agencies (TPA) and the dynamics related to the existence of the Queen's Academic Health Sciences Centre.

Governance

Details on governance activities during the start-up year for the South East Local Health Integration Network can be referenced in the "Message from the Chair" located at the beginning of this document.

Integrated Health Service Plan (IHSP)

The Road Map to the IHSP was received (Final draft January 19, 2006) and presented at the MOHLTC/LHIN briefing Feb 3, 2006

An IHSP Project Plan was developed with iterative reviews by the SE LHIN Board (Final discussion on March 13, 2006).

The Project Plan includes the following elements:

- A Project Steering Team (membership by three Board members, CEO, 2 senior LHIN staff),
- A Project Working Team composed of members nominated by all sectors within the LHIN jurisdiction (hospitals, Community Health Centres (CHC), community support services, mental health services, addiction services, Community Care Access Centres (CCACs), Long Term Care (LTC) facilities, plus the academic health sciences community, French-language population supported by participation by Health Services Intelligence Project) has set up with work scheduled to begin in April 2006.

The Request For Proposal for external consultants to manage the development of a draft Integrated Health Service Plan was developed, approved by the Steering Team and Board and released in March 2006:

- Seven companies from the MOHLTC Vendor of Record (VOR) lists were invited to submit proposals.
- Five proposals were received and reviewed by a Proposal Review Committee (two Board members, CEO, two senior staff).

- One proposal was selected by the Proposal Review Committee for recommendation to the Board for acceptance.
- March 28, 2006 the SE LHIN Board accepted and approved the proposal from the Hay Group.
- Final contract was prepared for March 28, 2006 signature
- Hay Group on site and work started prior to March 31, 2006

The final IHSP is expected to be approved by the Board in October of 2006.

Community Engagement

The Need to Engage

The South East Local Health Integration Network (LHIN) has a broad and challenging mandate to improve access to high quality health care for its residents through strengthened integration and coordination of health services. We know that we can only achieve this mandate by actively seeking out extensive community participation, sharing information and respectfully working together to make this vision a reality. We see community engagement as a critical underpinning for all that we do as a LHIN -- it facilitates success and emphasizes the importance of the relationship between the providers of health care services and the people that use these services.

We have already started the essential work of building strong relationships with our community. In fact, we have met with over 4,000 stakeholders thus far. We hosted large and small community information sessions and recruited Board members through a community-based recruitment process. Our Board and Staff continue to introduce themselves to individuals and groups in our communities.

While the past few months have provided us with an opportunity to meet many of the stakeholders in our community, we will now turn our attention to more formal and systematic community engagement for two reasons: first, we need active and continuing participation in the creation of our Integrated Health Services Plan (IHSP); and second, we need to share with everyone in

our community the foundation that will guide ongoing and future community engagement activities in our LHIN so that we can receive advice on our ability to facilitate broad participation in decision-making.

Ontarians, whether they are in rural or urban settings, from diverse, Francophone or First Nation communities, young or old, healthy or ill; feel strongly about their health care system from the perspective of how it is provided to the perspective of how it is used. We believe all Ontarians should have the opportunity to help craft the continuous evolution of this valuable system. To this end, the SE Local Health Integration Network intends to create the opportunities for meaningful input, thoughtful listening and fulsome discussions. We are therefore committed to extensive community engagement activities.

Financial Statements

As of March 31st, 2006, the South East Local Health Integration Network audited Statement of Financial Position represents net assets (cash) of \$28,370.

Auditor's Report - Deloitte & Touche LLP

To the Members of the Board of Directors of the South East Local Health Integration Network

We have audited the statement of financial position of South East Local Health Integration Network (the "LHIN") as at March 31, 2006 and the statements of operations and changes in net assets for the period from the date of incorporation July 9, 2005 to March 31, 2006. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the South East Local Health Integration Network as at March 31, 2006 and the results of its operations and its cash flows for the period from the date of incorporation July 9, 2005 to March 31, 2006 in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Toronto, Ontario

May 31, 2006

Statement of Financial Position

As at March 31, 2006

	2006
Assets	
Current Assets	
Cash	\$28,369
Capital assets (note 3)	1
	\$28,370
Liabilities and Net Assets	
Accounts payable and accrued liabilities (note 4)	-
Net assets	\$28,370
	\$28,370

Approved by the Board of Directors

Statement of Operations and Changes in Net Assets

Period from the date of incorporation July 9, 2005 to March 31, 2006

	2006
Revenue	
Ministry of Health and Long Term Care ("MOHLTC") Funding	\$2,600
MOHLTC payroll reimbursement	\$239,361
	\$241,961
Expenses*	
Salaries and Benefits	\$210,086
Office Supplies	\$532
Postage and Courier	\$94
Catering	\$403
Other	\$2,476
	\$213,591
Excess of Revenue Over Expenses	\$28,370
Net Assets, Beginning of Period	-
Net Assets, End of Period	\$28,370

* A significant portion of the South East LHIN operations during this fiscal period was managed by the Ministry of Health and Long-Term Care ("MOHLTC"). The remaining portion, representing only petty cash and payroll transactions, was managed by the South East LHIN office and is presented above. The portion managed by the MOHLTC is reflected in Notes 4 and 5 to these statements.

1. Description of Business

Formation and Status

The South East Local Health Integration Network was incorporated by Letters Patent on July 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the South East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in both the Act and the Memorandum of Understanding between the LHIN and the Ministry of Health and Long-Term Care ("MOHLTC"). Funding of the LHIN by MOHLTC in the fiscal year ended March 31, 2006 was made pursuant to the terms of a Performance Agreement.

LHIN Operations

The objects of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The South East LHIN is home to about 442,800 people, which encompass the areas of Hastings,

Prince Edward, Lennox and Addington, Frontenac, Leeds and Grenville Counties, the cities of Kingston, Belleville and Brockville, the towns of Smiths Falls and Prescott, and part of Lanark and Northumberland Counties.

Fiscal Period

These financial statements represent the activities of the LHIN from July 9, 2005, the date of incorporation, to March 31, 2006.

2. Significant Accounting Policies

Financial Statement Presentation

The financial statements have been prepared in accordance with the accounting standards for not-for-profit organizations published by the Canadian Institute of Chartered Accountants using the deferral method of reporting restricted contributions.

Revenue Recognition

Ministry of Health and Long-Term Care funding is recognized as revenue in the year in which the related expenses are incurred. Any designated funds for which the expenses have not been incurred are recorded as deferred revenue.

Use of Estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Capital Assets

The LHIN office maintains a record of assets purchased on its behalf by the MOHLTC. The nature of these assets includes:

- Leaseholds (arranged by Ontario Realty Corporation)
- Furniture and equipment
- Computer software and equipment

These assets have been reflected at a nominal dollar value of \$1, as the payment for these assets has been included in the expenditures of the MOHLTC.

4. Accounts Payable and Accrued Liabilities

The MOHLTC has included accounts payable and accrued liabilities totaling \$150,501 in its records on behalf of the LHIN as at March 31, 2006. These expenses are included in amounts disclosed in Note 5.

5. Expenses

All other operating expenses, other than those disclosed on the statement of operations, were approved and paid for on behalf of the LHIN by the MOHLTC. These expenses for the period ended March 31, 2006 are as follows:

Salaries and Benefits	\$66,805
Accommodation/occupancy	\$1,133,960
Common Services	\$42,126
Information Technology	\$73,355
Other expenditures	\$305,523
	\$1,621,769

6. Guaranties

(i) The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

(ii) An indemnity for the Chief Executive Officer was provided directly by the LHIN. Between March 28, 2006 and March 31, 2006, the directors, officers and employees of the LHIN received the benefit of Section 35 of the Act.

7. Statement of Cash Flows

A statement of cash flows has not been provided, as the information it would contain is readily determinable from the accompanying statements.

Annual Remuneration for Board Members

The reporting period for board members' remuneration includes the ten month period from June 2005 to March 31, 2006; this also ranges from one member to six members in total during this timeframe.

Per Diems	\$84,225
Travel Claims	\$13,740

Appendix A - Local Health System Integration Act 2006

The Local Health System Integration Act, 2006 was introduced on November 24, 2005 and received Royal Assent on March 28, 2006. The purpose of the Act is to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care and effective and efficient management of the health system at the local level by local health integration networks.

The Act creates 14 Local Health Integration Networks (LHINs) as Crown Agencies of the Ministry of Health and Long-Term Care. It gives LHINs the power to plan, co-ordinate and fund health care providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions agencies) in their specified geographic areas. It sets out the corporate organization of the LHINs, the powers of the LHIN Boards of Directors, and requires the LHINs to have an accountability agreement with the Minister of Health and Long-Term Care.

The Act provides the legislative framework for creating a health system in Ontario that is:

- Community-based: engages the local community about needs and priorities
- Based on Partnerships: system partners are Minister, Ministry, LHINs and service providers
- Forward Looking: emphasis on planning and priority setting
- Efficient: effective allocation of funding to achieve priorities
- Accountable: clearly defined expectations and measurement of achievement; monitoring and public reporting provide checks and balances in system
- Integrated: coordinated health care with focus on client needs

The Act sets out certain requirements and authorities for the Ministry and the LHINs in the areas of: planning, community engagement, funding, accountability and integration.

Planning and Community Engagement:

The Minister must develop a provincial strategic plan for the health system and make the plan public. Each LHIN is required to engage their community and Aboriginal and French Language local planning entities to develop an Integrated Health Service Plan for their local health system. Community is broadly defined in the Act and includes patients and others, health service providers, and employees. The Act identifies some of the methods LHINs would use to engage their community, including community meetings, focus groups, and advisory committees.

Funding and Accountability:

The Minister determines each LHIN's funding and enters into an accountability agreement that sets out performance goals and standards, reporting requirements, a spending plan, and a performance management process.

The Act ensures that people can access care outside of the LHIN in which they live. The LHIN boundaries do not restrict people in any way.

When the LHINs have funding authority, they will enter into service accountability agreements with health care providers to deliver health services in their local communities, in accordance with the LHINs accountability agreement with the Minister.

Integration:

To enable a coordinated health system, LHINs may facilitate integration discussions between health care providers, (e.g., transfer services to another location or provider, start or stop providing a service or change the amount of a service). LHINs will also have the power to require integration where they believe it is in the public interest. The Act also includes mechanisms to protect employees when services are integrated.

As of June 2005 not all parts of the Act have been proclaimed in force. A full copy of the legislation is available on e-laws at http://www.e-laws.gov.on.ca/home_E.asp?lang=en

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LOCAL HEALTH INTEGRATION NETWORK

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